Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
May 1, 2, 4, 2012	2012_07649 _0010	Complaint

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
50 SAMOR ROAD, SUITE 205, TORONTO, ON, M6A-1J6

Long-Term Care Home/Foyer de soins de longue durée

EATONVILLE CARE CENTRE
420 THE EAST MALL, ETOBICOKE, ON, M9B-3Z9

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

BAMBO OLUWADIMU (149)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care, the Registered dietitian, Registered staff, Personal Support Workers (PSWs), residents' families and residents.

During the course of the inspection, the inspector(s) observed resident care, reviewed resident's records and administrative records.

The following Inspection Protocols were used during this inspection:

Nutrition and Hydration

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following subsections:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee did not reassess and review the resident's plan of care when the resident's care needs changed.

Resident A was admitted on March 31, 2012 with history of poor food and fluid intake. The registered dietitian conducted resident A's initial nutritional assessment between April 2, 2012 and April 10, 2012. The registered dietitian assessed resident A to be at high nutritional risk and put interventions in place to monitor resident A's intake. A registered practical nurse indicated that the PSW assigned to resident A informed him/her about resident A's poor food and fluid intake and reported the concern to the registered nurse. The registered staff indicated to the inspector that he/she was aware of resident A's poor food and fluid intake. On April 16, 2012, resident A's daughter verbalized concerns about resident A's poor food and fluid intake to staff. Staff made a referral to the registered dietitian to assess resident A after resident A's daughter raised concerns about resident A's poor food and fluid intake. Between April 1, 2012 and April 17, 2012, resident A's intake was not monitored. On April 17, 2012, resident A was transferred to hospital after becoming unresponsive with blood pressure of 73/55 [s.6.(10)(b)].

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff reassess and review the resident's plan of care when the resident's care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following subsections:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee did not ensure that the staffing mix is consistent with residents' assessed care and safety needs.

Several PSWs reported to the inspector that they provide care to residents in a rush and were not always able to provide all required care to residents. A PSW also indicated that staff are not able to take their breaks because taking breaks would result in insufficient coverage for residents on the unit [r.31.(3)].

2. Several registered staff reported to the inspector that they provide care to resident in a rush, do not have enough time to reassess resident when their care needs change, and cannot spend quality time with residents when providing care. Several registered staff also indicated coming to work before their scheduled shift and staying after their scheduled shift to provide care to residents. A registered staff also indicated that staff do not take their breaks because taking breaks would result in insufficient coverage for residents on the unit [r.31.(3)].

3. Family members indicated that the current staffing pattern does not meet the needs of the residents. One family member reported to the inspector that it was not unusual to have to wait for hours to get assistance to change resident's incontinence's brief. Another family member reported to the inspector that he/she no longer approach staff for assistance because staff are always busy with other residents [r.31.(3)].

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the staffing mix is consistent with residents' assessed care and safety needs and meets the requirements set out in the Act and the Regulation, to be implemented voluntarily.

Issued on this 4th day of May, 2012

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs